MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

FRANK KEATING
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

December 18, 2002

Donna Schmidt, Project Officer
Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Urgent Request for Expedited Review of Waiver Amendment
Demonstration Project 11-W-00048/6

Dear Ms. Schmidt:

I am writing to request approval to amend Oklahoma's §1115(a) Research and Demonstration Waiver, effective January 1, 2003, and continuing throughout the remainder of the extension period until December 31, 2003. The proposed amendments are for the SoonerCare Plus program which is offered in 16 urban counties and carried out by four contracted health maintenance organizations in three service areas. The amendments would reduce required covered services to be comparable with the Authority's fee-for-service program and institute member cost-sharing in the form of nominal co-payments consistent with fee-for-service rules.

If approved, these changes will be incorporated in contract amendments for the MCOs. A beneficiary notice will also be disseminated.

If you have any questions or comments or would like more information, please contact the Director of SoonerCare and Care Management Services, Rebecca Pasternik-Ikard, at (405) 522-7208.

Sincerely,

Lynn V. Mitchell, MD, MPH
State Medicaid Director

cc: Bill Brooks, CMS Dallas Regional Office
Tammy Auseon, CMS Dallas Regional Office
Linda Territo, CMS Dallas Regional Office
Kathy Smith
Kevin Rupe
Mike Fogarty
Rebecca Pasternik-Ikard
Roland Davila
Debbie Ogles
Melinda Jones

Oklahoma Health Care Authority

§1115(a) Research and Demonstration Waiver Amendment Request

December 18, 2002

Amendment to replace Section IV.3, Benefits Package: Covered Services and Cost Sharing
Effective January 1, 2003

IV.3 Benefits Package: Covered Services and Cost Sharing

The Oklahoma Health Care Authority Board of Directors on December 12, 2002, approved benefit reductions and payment reductions for the ***SoonerCare*** Plus program in an effort to sustain the program despite dire agency and State budget circumstances. Oklahoma's constitution requires that all State agencies operate within a balanced budget. At the December Board meeting, a Declaration of Emergency was approved and nine budget reductions were approved. The reduction of the Scope of Benefits of ***SoonerCare*** Plus and corresponding reduction in the capitation rates paid the health plans comprised a forecasted $3.4 million savings to the agency. The total reductions approved totaled $5.8 million.

From the program's inception in June 1995 until the action by the OHCA Board, SoonerCare Plus had experienced increased enrollment and certain benefit expansions. The major barrier to ongoing annual funding by the Oklahoma Legislature in recent years has been the difference between benefits offered to managed care members in Oklahoma. In the rural areas of the state served by ***SoonerCare*** Choice, adult benefits were limited. ***SoonerCare*** Plus member adults, in comparison, received all medically necessary services.

Cost and Impact Data
Four health plans contract as ***SoonerCare*** Plus providers and in December 2002 serve 181,646 members. Members reside in urban service areas along a corridor of the most densely populated areas of the state. The Southwest service area is centered around Lawton, located in Comanche County. The Central service area extends around Oklahoma County and the Northeast service area encompasses Tulsa County. ***SoonerCare*** Plus members reside in a total of 16 counties.

OHCA's Finance Division projected that a reduction of six percent to every capitation payment cell and other contractual payment streams would achieve the desired state savings of $3.4 million. ***SoonerCare*** then prepared worksheets to notify each individual health plan of the proposed changes in compensation. These worksheets are attached as **Exhibit A**.

In collaboration with agency resource staff, ***SoonerCare*** staff then undertook the task of preparing a revised version of the ***SoonerCare*** Plus Benefits Package. The revised benefits package will permit plans greater discretion in managing benefits for adults and provide corollary cost savings to the plans. In addition, expanded cost sharing options will be afforded the plans and are addressed in the section below.

It is projected that some 35,000 adult ***SoonerCare*** Plus members will be impacted by the potential benefit and copayment changes.

To obtain benefit parity in the ***SoonerCare*** Plus program, the following program benefit minimums and changes will be implemented.

1. Inpatient hospital care – limited to 15 days per contract year for adults
2. Outpatient hospital services –
3. Physician services – limited to two per month for adults
4. Family planning services—
5. Over-the-counter contraceptives and diabetic supplies
6. Smoking cessation products –
7. Prescription drugs – limited to three per month for adults (with certain excluded products.)
8. Laboratory, radiology and other diagnostic services –
9. Behavioral health services --
10. EPSDT services –
11. Dental services – not required for adults.
12. Eye care services – not required for adults.
13. Emergency room services –
14. FQHC services
15. Short-term skilled or intermediate nursing facility care, or hospice services – not required for adults or children
16. Services in Institutions for Mental Diseases
17. Podiatry services
18. Durable medical equipment, including supplies –
19. Assitive technology
20. Prosthetic devices
21. Mammograms
22. Treatment for sexual violence (rape), child abuse and sexual abuse
23. Medical transportation (emergency and non-emergency)
24. Therapy services
25. Transplants
26. Inpatient treatment and medical detoxification
27. Outpatient treatment for persons with psychiatric, substance abuse and domestic violence problems
28. Residential treatment (restrictive)
29. Day treatment
30. Outpatient crisis intervention
31. Evaluation and testing
32. Intensive outpatient services
33. Psychosocial rehabilitation services
34. Homebased services
35. Rehabilitative case management
36. Therapeutic foster care
37. Dental services for ABD members – not required for adults
38. Vision services for ABD members – not required for adults
39. Enhanced services such as nutrition counseling; smoking cessation classes with targeted outreach for adolescents and pregnant women; childbirth education classes; parenting classes; diabetes, asthma, hemophilia and cystic fibrosis self-management and education

classes; living with HIV/AIDS instruction; and dental education requirements are removed.

Health plans will offer services through a managed care model, with the member's primary care physician coordinating the delivery of care. The primary care physician will serve as the case manager for each of his or her panel members. Hospitalization, diagnostic testing and specialty referrals will be ordered by the provider based on medical necessity and community standards of health care practice.

All beneficiaries will be eligible for the same minimum package of covered services, although contracted health plans may furnish additional benefits as the plans' prerogatives.

Services Excluded from the Pre-paid Benefit Package

A limited number of Title XIX services are not included in the capitated benefit package but contracted health plans are reimbursed on a fee-for-service basis for these wraparound benefits.

Summary of Services

The pre-paid minimum benefit package for ***SoonerCare*** Plus members is contained in **Exhibit B.**

Cost Sharing Provisions

Effective January 1, 2003, Health Plans are authorized by the Authority and CMS to collect nominal copayments from adult members – except for those members who are exempt, including members approved for care in nursing facilities and intermediate care facilities for the mentally retarded, family planning products including contraceptives, services furnished to pregnant women if the services are related to the pregnancy or to any other medical condition which may complicate the pregnancy. These copayments are consistent with those in the Medicaid Fee for Service program and are as follows:

A. $1.00 for prescriptions having a Medicaid allowable of $29.99 or less; and

B. $2.00 for prescriptions having a Medicaid allowable of $30.00 or more.

C. $3.00 per day for inpatient hospital services.

D. $3.00 per day for outpatient hospital services.

E. $3.00 per day for ambulatory surgery services, including those provided by freestanding ambulatory surgery centers.

F. $1.00 for each service rendered by physicians, optometrists, home health agencies, rural health clinics, certified registered nurse anesthetists and federally qualified health centers.

Health Plan providers may not deny care or services to an eligible member based on an individual's inability to pay the copayment. A person's assertion of inability to pay the copayment establishes this inability.

Member and Provider Education Efforts

Member

OHCA has developed a beneficiary notification letter to send to adults. The mailing is scheduled for December 19, 2002, to comply with 42 CFR 431.210. This notice has also been distributed to the health plans. The beneficiary notification letter is found at **Exhibit C**.

Provider

OHCA makes every effort to maintain an open dialog with the contracted ***SoonerCare*** Plus health plans. The day before the Board meeting, the plans and OHCA staff met to review in detail the proposed changes in benefits and cost sharing. The agency conducted a subsequent meeting with the MCOs on December 16, 200.

Plans were mailed a contract amendment, revised optional benefit package and the revised payment schedules following the board action on December 12, 2003. MCOs must respond to the amendment by December 23, 2002.

System Changes

Payment changes were initiated in the Medicaid Management Information System on December 12, 2002, following the Board meeting. The benefit and copay revisions have been evaluated for system changes at OHCA and none are needed.

Implementation Timeline

State revenue failures necessitate the implementation of these changes on January 1, 2003.

Exhibit A

Capitation, ABD Risk Adjustment and Other Payments

CommunityCare HMO

Current for 2003

Proposed for 2003 - 6% decrease

Oklahoma City	<1	1-5	6-14	15-20F	15-20M	21-44F	21-44M	45+
	$	$	$	$	$	$	$	$
TANF	308.66	67.38	97.56	118.32	126.69	104.64	95.12	173.58
		$	***$***	***$***	***$***	***$***	***$***	***$***
	$ 290.14	***63.34***	***91.71***	***111.22***	***119.09***	***98.36***	***89.41***	***163.17***
	$	$	$	$	$	$	$	$
SBHN	659.72	659.72	659.72	659.72	659.72	191.96	191.96	191.96
		$	***$***	***$***	***$***	***$***		***$***
	$ 620.14	***620.14***	***620.14***	***620.14***	***620.14***	***180.44***	***$ 180.44***	***180.44***
	$	$	$	$	$	$	$	$
ABD	358.22	358.22	358.22	358.22	358.22	511.53	511.53	511.53
		$	***$***	***$***	***$***	***$***		***$***
	$ 336.73	***336.73***	***336.73***	***336.73***	***336.73***	***480.84***	***$ 480.84***	***480.84***

			80/20 Split	100%
			$	$
Risk Adjustment Pool	$3.4 MM	Hemophilia Stop/Loss Threshold	12,480.00	249,500.00
	$3.196 MM		***$ 11,731.20***	***$ 234,530.00***
SPABD-SPTANF Pool	$1.2 MM			
			$	$
	$1.128 MM	Non-Hemophilia Stop/Loss Threshold	62,376.00	249,500.00
	$			
Resident PCP	5.00		***$ 58,633.44***	***$ 234,530.00***
	$4.70			
	$			
Resident Delivery	100.00			
	$94.00			

	$
Supplemental Delivery	2,790.00
	$ 2,622.60

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Heartland Health Plan of Oklahoma

Current for 2003

Proposed for 2003 - 6% decrease

Oklahoma City	<1	1-5	6-14	15-20F	15-20M	21-44F	21-44M	45+
	$	$	$	$	$	$	$	$
TANF	308.66	67.38	97.56	118.32	126.69	104.64	95.12	173.58
		$	***$***	***$***	***$***	***$***	***$***	***$***
	$ 290.14	***63.34***	***91.71***	***111.22***	***119.09***	***98.36***	***89.41***	***163.17***
	$	$	$	$	$	$	$	$
SBHN	659.72	659.72	659.72	659.72	659.72	191.96	191.96	191.96
		$	***$***	***$***	***$***	***$***		***$***
	$ 620.14	***620.14***	***620.14***	***620.14***	***620.14***	***180.44***	***$ 180.44***	***180.44***
	$	$	$	$	$	$	$	$
ABD	413.88	413.88	413.88	413.88	413.88	542.44	542.44	542.44
		$	***$***	***$***	***$***	***$***		***$***
	$ 389.05	***389.05***	***389.05***	***389.05***	***389.05***	***509.89***	***$ 509.89***	***509.89***

Tulsa	<1	1-5	6-14	15-20F	15-20M	21-44F	21-44M	45+
	$	$	$	$	$	$	$	$
TANF	356.21	71.68	94.80	123.65	110.85	118.72	108.75	149.24
		$	***$***	***$***	***$***	***$***		***$***
	$ 334.84	***67.38***	***89.11***	***116.23***	***104.20***	***111.60***	***$ 102.23***	***140.29***
	$	$	$	$	$	$	$	$
SBHN	659.72	659.72	659.72	659.72	659.72	191.96	191.96	191.96
		$	***$***	***$***	***$***	***$***		***$***
	$ 620.14	***620.14***	***620.14***	***620.14***	***620.14***	***180.44***	***$ 180.44***	***180.44***
	$	$	$	$	$	$	$	$
ABD	413.88	413.88	413.88	413.88	413.88	542.44	542.44	542.44
		$	***$***	***$***	***$***	***$***		***$***
	$ 389.05	***389.05***	***389.05***	***389.05***	***389.05***	***509.89***	***$ 509.89***	***509.89***

Risk Adjustment Pool	$3.4 MM
	$3.196 MM
SPABD-SPTANF Pool	$1.2 MM
	$1.128 MM
Resident PCP	$ 5.00
	$4.70
Resident Delivery	$ 100.00
	$94.00
Supplemental Delivery	$ 2,790.00
	$ 2,622.60

	80/20 Split	100%
Hemophilia Stop/Loss Threshold	$ 12,480.00	$ 249,500.00
	$ 11,731.20	***$ 234,530.00***
Non-Hemophilia Stop/Loss Threshold	$ 62,376.00	$ 249,500.00
	$ 58,633.44	***$ 234,530.00***

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Prime Advantage Health Plan

Current for 2003

Proposed for 2003 - 6% decrease

Lawton	<1	1-5	6-14	15-20F	15-20M	21-44F	21-44M	45+
	$	$	$	$	$	$	$	$
TANF	329.44	73.42	95.97	121.92	109.65	108.30	74.48	180.97
		$	***$***	***$***	***$***	***$***	***$***	***$***
	$ 309.67	***69.01***	***90.21***	***114.60***	***103.07***	***101.80***	***70.01***	***170.11***
	$	$	$	$	$	$	$	$
SBHN	659.72	659.72	659.72	659.72	659.72	191.96	191.96	191.96
		$	***$***	***$***	***$***	***$***		***$***
	$ 620.14	***620.14***	***620.14***	***620.14***	***620.14***	***180.44***	***$ 180.44***	***180.44***
	$	$	$	$	$	$	$	$
ABD	359.21	359.21	359.21	359.21	359.21	525.76	525.76	525.76
		$	***$***	***$***	***$***	***$***		***$***
	$ 337.66	***337.66***	***337.66***	***337.66***	***337.66***	***494.21***	***$ 494.21***	***494.21***

			80/20 Split	100%
			$	$
Risk Adjustment Pool	$3.4 MM	Hemophilia Stop/Loss Threshold	12,480.00	249,500.00
	$3.196 MM		***$ 11,731.20***	***$ 234,530.00***
SPABD-SPTANF Pool	$1.2 MM			
			$	$
	$1.128 MM	Non-Hemophilia Stop/Loss Threshold	62,376.00	249,500.00
	$			
Resident PCP	5.00		***$ 58,633.44***	***$ 234,530.00***
	$4.70			
	$			
Resident Delivery	100.00			

	$94.00
	$
Supplemental Delivery	2,790.00
	$ 2,622.60

Draft Proposal - Subject to OHCA Board Approval

UniCare of Oklahoma

Current for 2003

Proposed for 2003 - 6% decrease

Oklahoma City	<1	1-5	6-14	15-20F	15-20M	21-44F	21-44M	45+
TANF	$ 308.66	$ 67.38	$ 97.56	$ 118.32	$ 126.69	$ 104.64	$ 95.12	$ 173.58
	$ 290.14	***$ 63.34***	***$ 91.71***	***$ 111.22***	***$ 119.09***	***$ 98.36***	***$ 89.41***	***$ 163.17***
SBHN	$ 659.72	$ 659.72	$ 659.72	$ 659.72	$ 659.72	$ 191.96	$ 191.96	$ 191.96
	$ 620.14	***$ 620.14***	***$ 620.14***	***$ 620.14***	***$ 620.14***	***$ 180.44***	***$ 180.44***	***$ 180.44***
ABD	$ 387.17	$ 387.17	$ 387.17	$ 387.17	$ 387.17	$ 516.22	$ 516.22	$ 516.22
	$ 363.94	***$ 363.94***	***$ 363.94***	***$ 363.94***	***$ 363.94***	***$ 485.25***	***$ 485.25***	***$ 485.25***

Tulsa	<1	1-5	6-14	15-20F	15-20M	21-44F	21-44M	45+
TANF	$ 356.21	$ 71.68	$ 94.80	$ 123.65	$ 110.85	$ 118.72	$ 108.75	$ 149.24
	$ 334.84	***$ 67.38***	***$ 89.11***	***$ 116.23***	***$ 104.20***	***$ 111.60***	***$ 102.23***	***$ 140.29***
SBHN	$ 659.72	$ 659.72	$ 659.72	$ 659.72	$ 659.72	$ 191.96	$ 191.96	$ 191.96
	$ 620.14	***$ 620.14***	***$ 620.14***	***$ 620.14***	***$ 620.14***	***$ 180.44***	***$ 180.44***	***$ 180.44***
ABD	$ 387.17	$ 387.17	$ 387.17	$ 387.17	$ 387.17	$ 516.22	$ 516.22	$ 516.22
	$ 363.94	***$ 363.94***	***$ 363.94***	***$ 363.94***	***$ 363.94***	***$ 485.25***	***$ 485.25***	***$ 485.25***

Lawton	<1	1-5	6-14	15-20F	15-20M	21-44F	21-44M	45+
TANF	$ 329.44	$ 73.42	$ 95.97	$ 121.92	$ 109.65	$ 108.30	$ 74.48	$ 180.97
	$ 309.67	***$ 69.01***	***$ 90.21***	***$ 114.60***	***$ 103.07***	***$ 101.80***	***$ 70.01***	***$ 170.11***
SBHN	$ 659.72	$ 659.72	$ 659.72	$ 659.72	$ 659.72	$ 191.96	$ 191.96	$ 191.96
	$ 620.14	***$ 620.14***	***$ 620.14***	***$ 620.14***	***$ 620.14***	***$ 180.44***	***$ 180.44***	***$ 180.44***
ABD	$ 387.17	$ 387.17	$ 387.17	$ 387.17	$ 387.17	$ 516.22	$ 516.22	$ 516.22
	$ 363.94	***$ 363.94***	***$ 363.94***	***$ 363.94***	***$ 363.94***	***$ 485.25***	***$ 485.25***	***$ 485.25***

			80/20 Split	100%
Risk Adjustment Pool	$3.4 MM	Hemophilia Stop/Loss Threshold	$ 12,480.00	$ 249,500.00
	$3.196 MM		***$ 11,731.20***	***$ 234,530.00***
SPABD-SPTANF Pool	$1.2 MM			
	$1.128 MM	Non-Hemophilia Stop/Loss Threshold	$ 62,376.00	$ 249,500.00
Resident PCP	$ 5.00		***$ 58,633.44***	***$ 234,530.00***
	$4.70			
Resident Delivery	$ 100.00			
	$94.00			
Supplemental Delivery	$ 2,790.00	**Draft Proposal - Subject to OHCA Board Approval**		
	$ 2,622.60			

Exhibit B

Minimum Pre-paid Benefit Package

2003 PLUS MINIMUM BENEFIT PACKAGE

December 12, 2002

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:
Inpatient Hospital Care	Covered, as medically necessary, with authorization by a Health Plan physician.	15 inpatient hospital days per contract year, based on medical necessity.	all medically necessary inpatient hospital services.
Inpatient Stays for Observation		Coverage not required.	Coverage not required.
Outpatient Hospital Services (includes Ambulatory Surgery)	Covered, as medically necessary, with authorization by a Health Plan physician.	The following services, as medically necessary: dialysis, radiation therapy, ambulance, blood, pharmacy, laboratory, and other services as medically necessary.	All medically necessary outpatient hospital services.
Physician Services	Covered, as medically necessary, with authorization by a Health Plan physician.	PCP office visits as medically necessary. Specialty care visits may be limited to two per month except when in connection with emergency medical conditions.	all medically necessary physician services.

Obstetric Care		Provided as Maternity Care and Delivery, to include all routine care provided as well as any ultrasounds performed by the physician during the maternity cycle. Additional coverage as medically necessary for complete and targeted ultrasound by specialist, stand-by attendance at c-section, spinal anesthesia, amniocentesis.	Same as coverage for adults.
PLUS Covered Services	**Current PLUS Scope of Benefits**	**For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:**	**For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:**
Family Planning Services	Adolescent and adult. Contraceptive medical visits, family planning education and counseling, birth control methods ordered at a family planning visit. Tubal ligation for enrollees age 21 or over, per federal guidelines with federally-mandated consent forms. Includes lab services including hematocrit, dipstick UA, Pap smear, GC culture, serologic test for syphilis and rubella screening. Also, treatment of and follow-up for minor gynecological problems and infections.	Same as current PLUS benefits (May be subject to physician minimum service limitations)	No Change.

Over-the-Counter Contraceptives And Diabetic Supplies	OTC contraceptive devices and products, and diabetic supplies for enrollees (male and female).	OTC contraceptives are covered (contraceptives not to count toward prescription limit) Re: diabetic supplies coverage may be limited to: one glucometer, one spring loaded lancet device, and three replacement batteries per year. In addition coverage may be limited to 100 glucose test strips and 100 lancets per month, unless otherwise indicated by medical necessity.	OTC contraceptives as prescribed. Diabetic supplies as needed.
PLUS Covered Services	**Current PLUS Scope of Benefits**	**For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:**	**For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:**

Smoking Cessation Products	A benefit of up to 90 days covered once per twelve months. Any additional coverage is considered on a case by case basis.	a 90-day smoking cessation benefit consisting of Zyban, prescription nicotine patches, or Zyban/patch combination once per twelve months when prior authorized. Additional coverage may be considered on a case by case basis.	a 90-day smoking cessation benefit consisting of Zyban, prescription nicotine patches, or Zyban/patch combination once per twelve months when prior authorized. Additional coverage may be considered on a case by case basis.
Prescription Drugs	Therapeutic, non-cosmetic prescriptions covered (generic substitution allowed and encouraged) when prescribed by a Health Plan physician, or in accordance with RFP Section 2.5.2.	Three (3) prescriptions per month. Prescriptions for certain medical conditions are not to be included within the three prescription limit include: anti-neoplastics, anti-viral agents for the treatment of opportunistic infections for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS), certain prescriptions which require frequent laboratory monitoring, birth control prescriptions, over-the-counter contraceptives, hemophilia drugs, compensable smoking cessation products, certain solutions used in compounds (i.e., sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis.	all prescriptions as medically necessary.

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:
Outpatient Laboratory, Radiology and other Diagnostic Services	Covered, as medically necessary.	No Change	No Change
EPSDT Services (State Plan and Non-State Plan)	Covered for all children and young adults up to age 21 years.	Not applicable	1) Six screenings during the first year of life; 2) Two screenings in the second year; 3) One screening yearly for ages 2 through 5 years; 4) One screening every other year for ages 6 through 20 years; and 5) initial EPSDT screenings upon request by an eligible individual at any time without regard to whether the individual's age coincides with the established periodicity schedule.

Home Health Services	Home Health Services including, but not limited to, skilled nursing visits shall be provided as medically necessary, with authorization by a Health Plan physician.	36 nurse visits per contract year and standard supplies. Standard supplies include supplies routinely used by nurses during home health visits such as bandages, syringes, wound care supplies, ointments, etc.	36 nurse visits per contract year. More visits may be required as medically necessary.
PLUS Covered Services	**Current PLUS Scope of Benefits**	**For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:**	**For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:**
Dental Services	Comprehensive dental services for members up to age 21 years, including orthodontia, as delineated in State Dental Provider manual. Coverage for members age 21 and older are limited to emergency extractions and reconstructive dental surgery. If the dental condition is causing a substantial detriment to the enrollee's medical condition, then remediation of the dental condition is required.	Coverage not required. Emergency room dental care covered at the case rate.	No Change.

Eye Care Services	Comprehensive services for members up to age 21 years, including replacement lenses and frames as medically necessary. Coverage for members age 21 and older limited to treatment of diseases/injuries of the eye.	treatment of eye disease not related to refractive errors. There is no requirement for routine exams, treatment of refractive errors, lenses, frames, eye examinations for the purpose of prescribing glasses or for the purchase of visual aids.	No Change
Emergency Room Services	Coverage twenty four hours a day, seven days a week for true medical and behavioral health emergencies, or as authorized by Plan or Plan physician.	No Change; may apply case rate**.**	No Change; may apply case rate**.**
PLUS Covered Services	**Current PLUS Scope of Benefits**	**For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:**	**For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:**

FQHC Services, including physician services, services provided by physician assistants, nurse practitioners, clinical psychologists, or social workers and services and supplies as would otherwise be covered if furnished or incident to a physician's services and ancillary services, subject to limitations in the benefits package for services for adults.	Covered if the individual enrolls with a network FQHC provider as his or her PCP or, in the case of an individual who elects a PCP who is not affiliated with an FQHC, if that provider makes a referral to an FQHC for certain services on a pre-authorized basis. Patients may self-refer to network FQHC dental, vision, obstetrical, behavioral health and family planning providers, as specified by the RFP, subject to the limitations of the benefits package.	No Change	No Change
Short-term skilled, intermediate nursing care	Up to 30 days of skilled and intermediate nursing facility care is covered. Hospice services also covered when authorized by a Health Plan physician.	Coverage not required.	Coverage not required.
Hospice Service		Coverage not required.	Coverage not required
Respite Service		Coverage not required	Coverage not required.

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:
Services in Institutions for Mental Diseases (IMDs)	Covered for individuals under age 21 or over age 65 as specified in the existing State Plan.	No Change.	No Change.
Podiatry Services	Non-routine, medically necessary services covered, with authorization by a Health Plan physician.	medically necessary surgical procedures, x-rays, and outpatient visits. Coverage for procedures which are generally considered as preventative foot care, i.e. cutting or removal of corns, warts, callouses, or nails, is not required unless the diagnoses on the claim, i.e. diabetes, multiple sclerosis, cerebral vascular accident, peripheral vascular disease establishes the medical necessity for the service.	Same as for adults

Durable Medical Equipment, including medical supplies (see definition in Section 1.4).	Covered, as medically necessary, with authorization by a Health Plan physician. All of the following must be met to be considered medically necessary. The supplies or equipment or appliance must be: 1) a reasonable and necessary part of the recipient's treatment plan; 2) consistent with the symptoms, diagnosis, or medical condition of the illness or injury under treatment; 3) not furnished for the convenience of the recipient, the family, the attending practitioner, or other practitioner or supplier; and, 4) necessary and consistent with generally accepted medical standard (i.e., not experimental or investigational).	Coverage in accordance with Medicare guidelines. Coverage for orally administered and enteral nutritional supplements is not required. Parenteral supplements are to be covered based on permanent inoperative body organ. Coverage for orthotics not required.	No Change.
PLUS Covered Services	**Current PLUS Scope of Benefits**	**For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:**	**For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:**

Assistive Technology (see definition in Section 1.4).	Covered for individuals under age 21, as medically necessary, with authorization by a Health Plan physician. All of the following must be met to be considered medically necessary. The supplies or equipment or appliance must be: 1) a reasonable and necessary part of the recipient's treatment plan; 2) consistent with the symptoms, diagnosis, or medical condition of the illness or injury under treatment; 3) not furnished for the convenience of the recipient, the family, the attending practitioner, or other practitioner or supplier; and, 4) necessary and consistent with generally accepted medical standard (i.e., not experimental or investigational).	No Change	No Change

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:
Prosthetic Devices	Covered, as medically necessary, with authorization by a Health Plan physician. All of the following must be met to be considered medically necessary. The device or equipment or appliance must be: 1) a reasonable and necessary part of the recipient's treatment plan; 2) consistent with the symptoms, diagnosis, or medical condition of the illness or injury under treatment; 3) not furnished for the convenience of the recipient, the family, the attending practitioner, or other practitioner or supplier; and, 4) necessary and consistent with generally accepted medical standard (i.e., not experimental or investigational).	Under Medicaid Fee For Service, "Payment for prosthetic devices implanted during surgery is included within the level of care per diem rates except for: Cochlear Implants, Vagus Nerve Stimulator, and implantable medication pumps. Additional payment will be considered on a case by case basis. A prior authorization from the Medical Professional Services Unit of the OHCA will be required.	Under Medicaid Fee For Service, "Payment for prosthetic devices implanted during surgery is included within the level of care per diem rates except for: Cochlear Implants, Vagus Nerve Stimulator, and implantable medication pumps. Additional payment will be considered on a case by case basis. A prior authorization from the Medical Professional Services Unit of the OHCA will be required.
Artificial Limbs		Coverage not required	Coverage is required.
Mammograms	Once every five years for women aged 35 through 39 and once a year for women 40 and older.	No Change	Not applicable.

Treatment for Sexual Violence (Rape), Child Abuse, and Sexual Abuse	Covered, as medically necessary, with authorization by a Health Plan physician. Such exams are also covered if ordered by a court of competent jurisdiction or law enforcement agency in any situation.	No Change	No Change
PLUS Covered Services	**Current PLUS Scope of Benefits**	**For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:**	**For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:**
Medical Transportation (Emergency and Non-Emergency)	Covered, as medically necessary, with authorization by Health Plan (includes transportation for wraparound services).	No Change	No Change
Therapy Services	Physical therapy, occupational therapy, and speech therapy services covered as medically necessary with authorization by Health Plan physician and in accordance with section 2.5.3.1 and 2.5.3.2. .	Services not required.	No Change
Transplants	For adults, plan pre-approved kidney, corneal, bone marrow/stem cells, heart, liver, lung, SPK (simultaneous pancreas kidney), PAK (pancreas after kidney), and heart -lung organ transplants.	per diem rate for up to 15 days, and additional hospital charges associated with the transplant surgery up to a maximum payment of $150,000.	per diem rate, and additional additional hospital charges associated with the transplant surgery up to a maximum payment of $150,000.

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:

Behavioral Health Acute Inpatient Treatment and Medical Detoxification	Inpatient hospital care requiring twenty-four (24) hour supervision as a result of acute psychiatric illness or medical detoxification for substance abuse. Includes professional staff, under the direction of a physician, providing comprehensive care based on a treatment plan (on documentation of need) in a specialized behavioral health care unit in a hospital.	limited to inpatient hospital day limit of fifteen (15) days per contract year.	inpatient hospital days as medically necessary.
Inpatient Residential Treatment		Coverage not required.	No Change

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:

Outpatient Treatment for persons with psychiatric, substance abuse and/or domestic violence problems.	Individual Counseling: A therapeutic session with an individual conducted in accordance with a documented treatment plan focusing on treating his/her predetermined problem.	No Change	No Change
	Group Counseling: A therapeutic session with a group of individuals conducted in accordance with a documented treatment plan focusing on treating his/her predetermined problem.	No Change	No Change
	Family/Marital Counseling: A therapeutic session with family members/couples conducted in accordance with a documented treatment plan focusing on treating family/marital problems and goals.	No Change	No Change

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:

Residential Treatment (restrictive)	Supervised 24-hour care in conjunction with an intensive treatment program for children or pregnant women with psychiatric and/or substance abuse problems who require more intensive care than outpatient treatment. Services shall include a minimum of 22 hours per week of therapeutic services to include but not be limited to: individual counseling, group and family counseling, rehabilitative and expressive therapies.	Coverage not required	Service may be limited to psychiatric services only.

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:

Day Treatment	A time-limited, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic milieu. The program purpose is to provide intensive daily goal directed treatment to individuals experiencing acute symptoms or decompensating clinical conditions that severely impair their capacity to function adequately on a day-to-day basis, and who may be at risk of inpatient treatment without the daily program. The programs are normally provided at least three hours per day, five days a week. Treatment offered may include but need not be limited to: individual and group counseling; medication evaluation; family therapy; communication skills training; assertiveness training; stress management; problem solving techniques; and adjunctive therapeutic activities such as occupation therapy.	No Change	No Change

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:

Outpatient Crisis Intervention	An unanticipated, unscheduled emergency intervention requiring prompt action to resolve immediate, overwhelming problems that severely impair the individual's ability to function or maintain in the community. Must be available 24 hours a day with the ability to provide face-to-face intervention to include but not limited to: 24 hour assessment, evaluation and stabilization; access to inpatient treatment; diagnosis and evaluation in external settings, such as jails and general hospitals; and, referral services.	No Change	No Change

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:
Evaluation and Testing	A formal evaluation to establish problem identification, clinical diagnosis, or diagnostic impression. An evaluation shall include an assessment interview with the client and family, if deemed appropriate; may also include psychological testing, scaling of the severity of each problem identified for treatment; and/or, pertinent collaborative information. The evaluation will determine an appropriate course of assistance, which will be reflected in the treatment plan.	No Change	No Change

Intensive Outpatient Services (For mental health and/or substance abuse treatment.)	A therapeutic, structured, comprehensive program designed to provide treatment to improve or maintain a client's life management skills and ability to function in the community. The program is usually offered on a scheduled basis, a minimum of 2 hours per day at least 3 days a week.	No Change	No Change
PLUS Covered Services	**Current PLUS Scope of Benefits**	**For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:**	**For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:**

Psychosocial Rehabilitation Services	Psychosocial rehabilitation services are designed to assist participants in obtaining or developing the skills, resources, abilities, and support systems necessary to establish self-sufficiency in the community. Participants shall be given the opportunity to be involved in all functions of the program including administration, intake and orientation of new participants, outreach, hiring and training of staff, advocacy and evaluation of program effectiveness. The goal of psychosocial rehabilitation services shall be improved client functioning through the use of an empowerment model. Clients shall be encouraged toward increased interdependency and optional functioning in the broader community.	No Change	Coverage not required.

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:

Homebased Services	Homebased services involve a range of services of which the majority are delivered in the client's home or in other natural settings in the community. Homebased services should be scheduled as the needs of each family dictates, taking into account the fact such services must often be offered during evening and weekend hours. In addition, Homebased services may be available on an emergency basis to all families participating in the program. Services to be provided may include but are not limited to: 24 hour crisis intervention with Homebased families; individual and family counseling; parent education and training on behavior management. Intensive therapy and support services to families of children with acute psychiatric problems for the purpose of preventing the child's removal from the home to more restrictive care. Homebased services are also appropriate for adults who are experiencing acute mental health episode or to a person designated as SMI.	No Change.	No Change

PLUS Covered Services	Current PLUS Scope of Benefits	For Adults (TANF/ABD/SBHN) Age 21 and Older, must provide a minimum of:	For Children (TANF/ABD/SBHN) Under the Age of 21, must provide a minimum of:
Rehabilitative Case Management	Rehabilitative Case Management services work toward assuring access to services provided within the plan. Case management services also include referral, linkage, and advocacy in order to assist the client in gaining access to appropriate community resources.	No Change	No Change

Therapeutic Foster Care (Residential Behavioral Management)	Therapeutic foster care (TFC) is a treatment modality to assist emotionally disturbed children in developing improved abilities to function in a non-institutional setting. It is designed to provide foster parents who are trained and prepared to provide in-home care to children who are experiencing serious emotional disturbance. TFC is provided by an agency approved by DHS with an existing contract with the Authority for this service.	Not applicable	Coverage not required.

Exhibit C

Beneficiary Notification Letter

Head of household
Address
Address 2
City, State ZIP

Re: *SoonerCare Plus* Program Changes on January 1, 2003

Dear ***SoonerCare*** Plus Member:

It is with much regret I must inform you of some changes in the ***SoonerCare Plus*** Program effective January 1, 2003. Our State is experiencing a revenue shortfall and OHCA must revise and balance its budget. As a result we have given the Health Plans greater leeway to control the cost of services that you receive. Below we have listed some examples of the types of services that may be controlled. This will likely mean fewer services to you than you now receive.

For **adults,** your health plan may:

- Limit your prescriptions to 3 per month. Some drugs will not count toward the limit if you have certain conditions such as HIV/AIDS;
- Limit specialty doctor office visits to 2 per month;
- Limit hospital days to 15 per year;
- Limit feeding supplements and some diabetic supplies;
- Limit home health visits by a nurse to 36 per year;
- Reduce other benefits such as hospice services, and respite services;
- End speech, physical or occupational therapy;
- End dental and vision services;
- End coverage of thirty (30) days of skilled nursing care.

One additional change is that we are allowing the Health Plans to charge certain copayments regarding the care you receive from the plans. Those copayments that can be charged for services only to adults are:

- $1 for each drug costing $29.99 or less;
- $2 for each drug costing $30.00 or more;
- $3 a day for Inpatient and Outpatient hospital services;
- $1 per physician service;
- $1 per home health care service.

We very much regret that we have to take this action but the law requires it. All of these changes will make the benefits you receive in the ***Plus*** program consistent with the rest of our Medicaid program. You will not receive any administrative review from the Plans or the Health Care Authority regarding the Plan changes as a result of this action. We sincerely hope that during 2003 we are able to reinstate these services that you now receive.

Your health plan may give you more information about benefit changes. We suggest you contact your Health Plan member services for specific questions concerning your services.

Sincerely,

Mike Fogarty